CACFP INCOME ELIGIBILITY APPLICATION FOR CHILD CARE CENTER PARTICIPANT

PART 1A - CHILD'S NAME
(Please complete only one
application form per child) : _____

Last First MI Date of Birth

PART 2A – HOUSEHOLDS WHICH ARE CURRENTLY RECEIVING BENEFITS THROUGH THE SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP), OR FAMILIES FIRST (FF) CASH ASSISTANCE OR FAMILIES FIRST (FF) CHILD CARE ASSISTANCE (If your household is now receiving benefits under one or more of these programs, complete this part, and sign and date the statement in Part 4 – Do not complete Part 2B.)

ACCENT Case No. for SNAP or FF Cash Assistance: _____ **OR** FF Child Care Assistance Case No.: _____

PART 2B – ALL OTHER HOUSEHOLDS (If no information is entered in Part 2A above, complete this part, and sign and date the statement in Part 4. Attach additional sheets as necessary)

Names of All Household Members	Earnings from Work (Before Deductions)	Child Support, Alimony or Other Income	Payments Received from Pensions, Retirement, & Social Security
1.	$_____ per year	$_____ per year	$_____ per year
2.	$_____ per year	$_____ per year	$_____ per year
3.	$_____ per year	$_____ per year	$_____ per year
4.	$_____ per year	$_____ per year	$_____ per year

Total Number of Household Members: ___ Total Yearly Income for Household from All Sources: $ _____ Yearly income is calculated as follows: Multiply Weekly income by 52, Bi-weekly income (received every two weeks) by 26, Semi-monthly income (received twice a month) by 24, and Monthly income by 12. Do not round up any numbers.

PART 2C – FOSTER CHILD (Complete this part, and sign and date the statement in Part 4.) If this is a foster child, check here: **____** and identify the child's income and how often it is received here: $ _____ per _____.

PART 3 – Medicaid and State Children's Health Insurance Programs – Please check if you do **not** want the information in this application to be shared with the Medicaid and State Children's Health Insurance Programs: ___ DO NOT WANT APPLICATION INFORMATION TO BE SHARED WITH THE MEDICAID AND STATE CHILDREN'S HEALTH INSURANCE PROGRAMS.

PART 4 – SIGNATURE (An adult household member must sign the application.)

PENALTIES FOR MISREPRESENTATION: I certify that all of the above information is true and correct and that the Supplemental Nutrition Assistance Program or Families First case number is correct or that all income is reported. I understand that this information is being given for the receipt of Federal Funds; that institution officials may verify the information on the statement and the deliberate misrepresentation of the information may subject me to prosecution under applicable State and Federal laws.

Printed Name of Adult :	Signature of Adult:	Social Security Number:

Street:	City:	State and Zip Code:	Home Telephone:

PART 5 – ETHNIC/RACIAL IDENTITY (**You are not required to answer this question**.):

For Ethnicity, please check one of the following: ___ Hispanic or Latino ___ Not Hispanic or Latino (*Hispanic or Latino:* A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.)

For Race, please check one or more of the following: ___ American Indian or Alaskan Native ___ Asian ___ Black or African American ___ Native Hawaiian or Other Pacific Islander ___ White (*American Indian or Alaskan Native:* A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment. *Asian:* A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam. *Black or African American:* A person having origins in any of the black racial groups of Africa. *Native Hawaiian or Other Pacific Islander:* A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands. W*hite:* A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.)

FOR INSTITUTION OR SPONSOR STAFF USE ONLY: Eligibility Classification (Circle) Free Reduced-Price **or** Paid
Basis for Classification (Circle) Categorically Eligible **or** Income Eligible

Determining Official Signature: _____ Date: _____

HS-1949 (Revised 12/08)

INCOME ELIGIBILITY APPLICATION INSTRUCTIONS

PART 1A – PARTICIPANT INFORMATION: All HOUSEHOLDS COMPLETE THIS PART.

(1) Print the name of the child(ren) enrolled at the child care institution.

PART 2A – HOUSEHOLDS RECEIVING SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM BENEFITS, FAMILIES FIRST CASH ASSISTANCE OR FAMILIES FIRST CHILD CARE ASSISTANCE: COMPLETE THIS PART AND PART 4.

(1) Enter your household's current case number for Supplemental Nutrition Assistance Program , Families First Cash Assistance or Families First Child Care Assistance. Do not complete Part 2B.

(2) An adult household member must sign the statement in Part 3.

PART 2B - ALL OTHER HOUSEHOLDS: COMPLETE THIS PART AND PART 4.

(1) Write the names of everyone in your household.

(2) Write the amount of the income received on a yearly basis for each household member. The income may be for the current month, the amount projected for the first month the application is made for, or for the month prior to application. This income is the amount before taxes or any deductions are made. Also, indicate the source of the income. Refer to examples below for income to report.

INCOME TO REPORT

Earnings from Work	Retirement/Social Security	Other Income Sources	Child Support/Alimony
Wages/salaries/tips	Pensions	Disability benefits	Alimony/child support
Strike benefits	Supplemental Security Income	Cash withdrawn from savings	benefits/payments
Unemployment benefits	Retirement income	Interest/dividends	
Worker's Compensation	Veteran's payments	Income from estates/trusts/investments	
Net income from self-employment	Social Security Income	Regular contributions from persons not living in the household	
		Net royalties/annuities/net rental income	

PART 2C - HOUSEHOLDS WITH A FOSTER CHILD: COMPLETE THIS PART AND PART 4 – **A foster child is the legal responsibility of a children services agency or court.**

(1) List the foster child's "personal use" income and how often it is received. Write "0" if the foster child does not have "personal use" income. - Do not list any other children, household members or income. **"Personal use"** income is (a) money provided by the children services agency and identified by category for the child's personal use, such as for clothing, school fees, and allowances; and (b) all other money the child gets, such as money from his/her family and money from the child's full-time or regular part-time jobs.

(2) A foster parent or other official representing the child must sign the statement in PART 4.

PART 3 – MEDICAID AND STATE CHILDREN'S HEALTH INSURANCE PROGRAMS – Federal law allows the sharing of the information on this application with Medicaid and State Children's Health Insurance Programs. At this time, no procedures are in place to share this information. Since the procedures to share this information with the Medicaid and State Children's Health Insurance Programs may be established in the future, please indicate if you do not want this information to be shared. The Medicaid and State Children's Health Insurance Programs can only use the information to identify children who may be eligible for free or low cost health insurance and to enroll them in either Medicaid or the State Children's Health Insurance Program. They are not allowed to use the information for any other purpose. If this information is not shared, it will not affect the eligibility of your child(ren) for free or reduced-price meals. If you do not want to share the information with the Medicaid and State Children's Health Insurance Programs, please indicate this decision by entering a check.

PART 4 – SIGNATURE AND SOCIAL SECURITY NUMBER: All households complete this part.

(1) All income eligibility statements must have the signature of an adult household member.

(2) The adult household member who signs the statement must include his/her Social Security Number. If he/she does not have a Social Security Number, write "none". If you listed an ACCENT case number for Supplemental Nutrition Assistance Program or Families First cash assistance, or a case number for Families First Child Care Assistance, a Social Security Number is not needed.

(3) The income eligibility application is valid for one calendar year from the date of the signature of the Determining Official. You will be contacted by the staff of the child care institution serving your child(ren) to update the information contained in this application before the close of the eligibility period. The staff of the child care institution is required to verify and certify the eligibility of your household every 12 months. Section 9 of the National School Lunch Act requires that, unless the participant's Supplemental Nutrition Assistance Program or Families First case number is provided, you must include the Social Security Number of the household member signing the statement or an indication that the household member signing the statement does not possess a Social Security Number. Provision of a Social Security Number is not mandatory, but if a Social Security Number is not provided or an indication is not made that the adult household member signing the statement does not have one, the statement cannot be approved. The Social Security Number may be used to identify the household member in carrying out efforts to verify the correctness of information stated on the statement. These verification efforts may be carried out through program reviews, audits, and investigations and may include contacting employers to determine income, contacting a Supplemental Nutrition Assistance Program or Families First office to determine current certification for receipt of Supplemental Nutrition Assistance Program or Families First cash assistance, contacting the State employment security office to determine the amount of benefits received and checking the documentation produced by the household member to prove the amount of income received. These efforts may result in a loss or reduction of benefits, administrative claims, or legal actions if incorrect information is reported.

PART 5 - RACIAL/ETHNIC IDENTITY: You are **not required** to answer this question to receive meal benefits. However, this information will help ensure that everyone is treated fairly.

No person shall be excluded from participation in, be denied benefits of, or be otherwise subjected to discrimination in the CACFP on the grounds of race, color, sex, age, disability, national origin, or any other classification protected by Federal, Tennessee State constitutional, or statutory law.

CHILD AND ADULT CARE FOOD PROGRAM
SAMPLE PARENT/GUARDIAN LETTER FOR
NONPRICING CHILD CARE CENTER

Dear Parent/Guradian:

This child care facility participates in the Child and Adult Care Food Program (CACFP) which is administered by the Tennessee Department of Human Services and funded by the U.S. Department of Agriculture. The CACFP provides reimbursements to our facility for the costs of serving nutritious meals to all enrolled children. This allows our facility to better serve your child(ren).

As provided by the program's regulations, the amount of reimbursement which we may receive for our meal services is dependent upon the income eligibility of your child(ren). The eligibility categories for enrolled children are free, reduced-price and paid. The highest meal reimbursement is provided for children who are eligible for the free meal category. The lowest meal reimbursement is provided for children in the paid meal category. The eligibility of each enrolled child must be updated at least once each year.

To determine the amount of meal reimbursements to be received by our facility for your child(ren), we need your assistance. Copies of the income eligibility application and income guidelines for the reduced-price meal category are attached. Please complete, sign and date this application, and return it to our facility. Your application will be placed in a secured file at our facility and treated as confidential information. The application may be verified by authorized state and federal officials.

For clarification purposes in completing the application, "household" is defined as a group of related or non-related individuals (not residents of an institution or boarding house) who are living as one economic unit. If you have more than one child enrolled at our facility, please complete a separate application for each child.

If you now receive benefits under the Supplemental Nutrition Assistance Program, Families First Cash Assistance or Families First Child Care Assistance Programs for your child(ren), you do not have to enter any income information on the application. If these benefits are received, please only provide your case number(s) for these programs, and the name of your child who is enrolled at our facility. Please note that the receipt of Families First Child Care Assistance is identified by the code "FF" in the category section of the child care certificate. You are required to notify our facility if the benefits under the Supplemental Nutrition Assistance Program, Families First Cash Assistance or Families First Child Care Assistance Programs are terminated for your child(ren).

If you do not receive benefits under the Supplemental Nutrition Assistance Program, Families First Cash Assistance or Families First Child Care Assistance Programs, please provide income information for your household. Also, if codes of AR, TFF or CCD appear in the category section of your child care certificate(s), please provide the income information as requested on the application. The income to be reported on the application should include the gross income of all members of your household. If your household income is equal to or less than the attached income guidelines, your child(ren) are eligible for the free or reduced-price meal reimbursements. The loss of income through the unemployment of any members of your

household may qualify your child(ren) for the free or reduced-price meal categories during the period of unemployment. In completing the attached application, please enter the names of all members of your household, the yearly amount of income each member now receives and the source of the income, and the Social Security Number of the primary wage earner or the adult household member who signs the application. If the adult household member does not have a Social Security Number, please enter "none". Please be sure that an adult member of your household signs and dates the application. To enter yearly income amounts, you will need to convert your income as follows: Multiply Weekly income by 52, Bi-weekly income (received every two weeks) by 26, Semi-monthly income (received twice a month) by 24, and Monthly income by 12. Do not round up any numbers during the conversion.

In certain cases, foster children are eligible for the free or reduced-price categories regardless of the income of the household in which these children reside. If your household has a foster child who is enrolled in our facility, please contact us for more information.

Federal law allows the sharing of the information on your income eligibility application with the Medicaid and State Children's Health Insurance Programs. At this time, no procedures are in place to disclose this information. Since the procedures to share this information with the Medicaid and State Children's Health Insurance Programs may be established in the future, please indicate if you do not want this information to be shared. The Medicaid and State Children's Health Insurance Programs can only use the information to identify children who may be eligible for free or low cost health insurance and to enroll them in either Medicaid or the State Children's Health Insurance Program. They are not allowed to use the information for any other purpose. If this information is not shared, it will not affect the eligibility of your child(ren) for free or reduced-price meals. If you do not want to share the information with the Medicaid and State Children's Health Insurance Programs, please indicate this decision by entering a check in Part 3 of the income eligibility application.

The meal services provided by our child care institution are available to all enrolled children regardless of race, color, national origin, sex, disability, or age. If you believe that you or your child(ren) have been discriminated against, you may file a grievance. The guidance procedures are attached. You may also immediately write to one or both of the following addresses:

U.S. Department of Agriculture
Director of Office of Civil Rights
Whitten Building, Room 326-W
1400 Independence Avenue, SW
Washington, DC 20250-9410
Telephone: (202) 720-5964 (Voice and TDD)

Tennessee Department of Human Services
Child and Adult Care Services
400 Deaderick Street
Nashville, Tennessee 37248-9500
Telephone (615) 313-4749

You may also file a complaint with our institution.

Please return the completed and signed application by _____ to

_____

Name of Authorized Official for Child Care Institution

_____

Name of Child Care Institution

_____

Street Address

_____

City State Zip Code

Thank you for your cooperation.

Sincerely,

_____

Name of Title of Facility Representative

_____

Date

Attachments: Income Eligibility Application
Income Eligibility Guidelines for Reduced-Price Meals
Grievance Form and Procedures